General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Herrington Medical Centre Pharm., Philadelphia Lane, Herrington Burn, HOUGHTON LE SPRING, Tyne and Wear, DH4 4LE

Pharmacy reference: 1037495

Type of pharmacy: Community

Date of inspection: 06/09/2022

Pharmacy context

The pharmacy is adjacent to a medical centre in Herrington. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs to help them take their medicines correctly. They deliver medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy doesn’t adequately manage all the risks with its services. The pharmacy doesn’t have complete and up-to-date written procedures that reflect the pharmacy’s current practice. This includes the management of near miss errors and dispensing incidents, and the pharmacy's technology systems. Pharmacy team members are unclear about how to provide services safely in certain circumstances
		1.2	Standard not met	Pharmacy team members do not record or analyse their mistakes. And they do not consider errors that occur in all parts of the dispensing process that are not mitigated by the robotic dispensing technology installed.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't adequately identify and manage all the risks associated with its services. The pharmacy does not have written procedures for several key parts of its services. Several of the written procedures it does have are out of date and do not reflect the way the pharmacy provides its services. And pharmacy team members are unclear about how to provide their services safely in certain circumstances. Team members discuss some of the errors they make in the dispensing process, but do not record or fully analyse their mistakes. So, they may miss opportunities to learn and make services safer. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information.

Inspector's evidence

The pharmacy had some documented standard operating procedures (SOPs) in place. These included procedures to help pharmacy team members safely receive prescriptions into the pharmacy. And to manually assemble and label prescriptions. The pharmacy had a dispensing robot, which it used to help team members pick medicines to dispense. But the documented procedures available did not include any information about how team members should use the robot as part of their dispensing processes. This meant that many of the documented procedures contained information that was no longer relevant to the pharmacy, despite being reviewed by the superintendent pharmacist (SI) and read by pharmacy team members in 2021. Pharmacy team members explained clearly how they used the robot to help them dispense. And they competently demonstrated various processes, such as dispensing a prescription and adding stock to the robotic system. Several key documented procedures were missing. For example, there was no documented procedure to guide pharmacy team members about what to do if they had a safeguarding concern about a vulnerable person. And there was no written procedure about how pharmacy team members should respond to or document mistakes that happened during the dispensing process. There were also no documented procedures to help team members understand their responsibilities in the absence of a responsible pharmacist (RP). When questioned, pharmacy team members were not clear about what they could and could not do if the RP was absent in various circumstances. This meant there was a risk of team members providing medicines to people without the proper oversight of a pharmacist.

Pharmacy team members did not record near miss errors they made while dispensing. They explained they discussed errors when they happened to make everyone aware. Team members said they relied on the robot to reduce the near miss errors they made. And the robot had reduced the number of picking errors made during the dispensing process. But team members had not identified the need to continue to monitor and record errors that occurred in other activities carried out by people during the dispensing process. Team members could not give any examples of any changes they had made in response to their mistakes to make their services safer. The pharmacy did not have a documented procedure available to help team members respond to a mistake that had been given out to someone. These dispensing errors were recorded by the SI. The records available were very brief. And they contained little or no information about why the mistakes had happened or what the pharmacy had changed to make their services safer and prevent a recurrence.

The pharmacy collected feedback from people using questionnaires. Following feedback, the pharmacy had recently installed a machine so people could pay for the pharmacy's services using a debit or credit

card. The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy maintained a responsible pharmacist record electronically. The sample of the records seen had several gaps in the sign-out time of the RP, which meant it was not a complete record. The pharmacist was displaying their responsible pharmacist notice to people in the retail area. The pharmacy kept controlled drug (CD) registers complete. It kept running balances in all registers. Pharmacy team members audited the running balances against the physical stock quantities each time they made an entry in the register. This meant that registers for CDs that were not used often were not frequently audited. Some CD registers contained entries which contained mistakes that had been crossed or scribbled out. In some cases, this meant it was difficult to follow the audit trail of what had gone wrong and how the mistakes had been corrected. The pharmacy kept a register of CDs returned by people for destruction. The pharmacy kept private prescriptions records in a paper register, which was complete.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in locked bins, which were emptied regularly by a secure waste disposal contractor. Pharmacy team members explained how they protected people's privacy and confidentiality. They gave examples of how they would be mindful of people’s privacy when speaking to them about their medicines. And how they were careful not to leave sensitive documents, such as prescriptions, around the retail counter. The pharmacy did not have a documented SOP about confidentiality and data protection to help them achieve this. Pharmacy team members gave some examples of symptoms that would raise their concerns about vulnerable children and adults. They explained how they would refer to the pharmacist. The pharmacy did not have a documented procedure for dealing with concerns about children and vulnerable adults. Team members had completed training in 2021.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete some ad hoc appropriate training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), a locum pharmacist, two pharmacy technicians and a trainee dispenser. Pharmacy team members completed training ad-hoc by reading various materials and by completing training modules provided by the NHS e-learning for healthcare platform when available. They had recently completed modules about LGBTQ+ in healthcare and safeguarding. The pharmacy did not have an appraisal process for pharmacy team members.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. One example was their input in changing the pharmacy's layout after a refit. Pharmacy team members explained they would raise professional concerns with the SI or the locum pharmacist, who worked at the pharmacy regularly. They felt comfortable raising concerns. They were confident that concerns would be considered, and changes would be made where they were needed. They explained that if they had a concern they could not raise internally, they would contact the National Pharmacy Association (NPA) or GPhC for advice. The pharmacy did not have a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. The pharmacy has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. It was generally tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It kept equipment and stock on shelves throughout the premises, and in the dispensing robot. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional, including the pharmacy's exterior which portrayed a professional healthcare setting. The pharmacy's professional areas were well defined by the layout and were well signposted from the retail area. Pharmacy team members prevented access to the restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people, including people using a wheelchair. The pharmacy has some systems in place to help provide its services safely and effectively. It sources its medicines appropriately. And it stores and generally manages its medicines adequately. Pharmacy team members provide some people with advice and information about high-risk medicines. But they don't always routinely provide people with written information to help them take and manage their medicines safely.

Inspector's evidence

The pharmacy had level access from the street. People knocked on the door to attract attention if they needed help. Pharmacy team members could use the prescription medication records (PMR) system to produce large-print labels to help people with visual impairment. And they ensured if needed the braille on the packaging was clearly available for people to use. They explained how they would use written communication to help people with a hearing impairment.

The pharmacy had a dispensing robot that pharmacy team members used to help select medicines to be dispensed. Prescriptions were downloaded electronically. Pharmacy team members also scanned barcodes on electronic prescription tokens and occasionally entered prescriptions into the system manually. The robot then used this information to select the correct medicines. Pharmacy team members then attached labels to the correct medicines that had been picked. Pharmacy team members explained how they filled the robot with stock, using 2D QR codes or barcodes printed on packs. The codes enabled the robot to identify each medicine and brand to determine where to store the medicine and how to recognise it when required. Pharmacy team members clearly explained how they used the robot. And how it supported them to dispense prescriptions accurately. But the pharmacy did not have a documented procedure available to help them do this safely. Or to help new team members understand how to dispense using the technology.

The pharmacy used the robot to monitor stock for short-dated and expired medicines. The robot determined the medicines expiry date via the 2D QR code on each pack. If the pack did not have a QR code, or was an incomplete pack, pharmacy team members entered the expiry date into the robot's system manually when they placed the item in the system. Each month, pharmacy team members used the system's data to retrieve any medicines expiring that month for disposal. The pharmacy did not have a process in place to regularly monitor and record short-dated and expired items that were not kept in the robot's cabinet. Team members said the amount of stock that was not kept in the robot was relatively small. And they checked the expiry dates of medicines each time they assembled and dispensed a prescription. But there were no documented procedures available to help them do this effectively and in a consistent way. After a search of the pharmacy's shelves, the inspector did not find any out-of-date medicines.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. A significant proportion of these were outsourced to another local pharmacy to prepare. The SI explained the pharmacy had collected verbal consent from people to have their packs dispensed by another pharmacy. Their consent had not been recorded. Both the pharmacy and the off-site contractor attached labels to the packs, so people had written instructions of how to take their medicines. Neither

pharmacy included descriptions of what the medicines looked like, so they could be identified in the packs. And neither routinely provided people with patient information leaflets about their medicines each month. Pharmacy team members managed any changes made to all packs. They communicated changes to their contractor pharmacy verbally after they had reconciled and obtained the necessary prescriptions to be able to assemble the packs.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a pregnancy prevention programme. The pharmacy delivered medicines to people, and it recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves and in the robot's cabinet, and it kept all stock in restricted areas of the premises where necessary. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the fridge where medicines were stored each day, and they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had a shredder available to destroy its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view. The pharmacy had a dispensing robot in place. Pharmacy team members were able to quickly obtain technical assistance in the event of a breakdown.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.